American College of Prosthodontists
Global Alliance Membership Application

Please type or print clearly. (An incomplete application will be returned and will delay activation of membership.)

First Name ________ Middle Initial ________ Last Name ________

Date of Birth: __________________ Gender (check one): ☐ Male ☐ Female

Primary Office Information: ☐ Preferred Mailing/Billing Address (Choose only one)

Company/Institution

Title

Address Line 1

Address Line 2

Address Line 3

City State Postal Code Country

Phone Fax

E-mail *Required for communication purposes

Secondary Office Information: ☐ Preferred Mailing/Billing Address (Choose only one)

Company/Institution

Address Line 1

Address Line 2

Address Line 3

City State Postal Code Country

Phone Fax

E-mail *Required for communication purposes Web site

Spouse Information: ☐ Print Spouse's Name in the Membership Directory

First Name Middle Initial Last Name

<u>Home Information</u>: ☐ Preferred Mailing/Billing Address (Choose only one)

____
Address Line 1

____
Address Line 2

____
Address Line 3

____
City State Postal Code Country

________________________________ _____________________________________
Phone Fax

____
E-mail *Required for communication purposes

<u>Education</u>: Degrees Earned (check all that apply):

☐ DDS ☐ DMD ☐ DVM ☐ Ph.D. ☐ MS ☐ MA ☐ MSD ☐ MPH ☐ BA ☐ BS

Additional Degrees not listed above: ____

________________________________ _______ ______________ ________________
Dental School Attended State Country Graduation Date

________________________________ _______ ______________ ________________
Prosthodontic Training Program State Country Graduation Date

<u>Primary Activity</u>: ☐ Private Practice ☐ Military ☐ Education ☐ Veterans Administration

<u>Secondary Activity</u>: ☐ Education ☐ Administration ☐ Consultant ☐ Hospital Dentist ☐ Research

<u>Faculty Appointment</u> (if applicable):

Undergraduate Faculty Position/Title: ____

Institution: ______________________________ % Time Teaching Undergraduate: ___________

Postgraduate Faculty Position/Title:____

Institution: ______________________________ % Time Teaching Postgraduate: ____________

<u>ACP Membership Directory Listing</u>:

☐ Print my ***Name Only*** in the Membership Directory (<u>excludes</u> **ALL** contact information)

Choose any combination from the following options:

- ☐ Print *Primary Office Address* (includes complete Primary Office contact information)
- ☐ Print *Secondary Office Address* (includes complete Secondary Office contact information)
- ☐ Print *Home Address* (includes complete Home contact information)

Communications: **Please review the communication options carefully.** If you have additional questions, or concerns please contact Membership Services for clarification.

☐ The ACP occasionally makes available its members' addresses (excluding telephone and e-mail) to vendors who provide products and services to the association community. If you do **not** wish to be included in these lists, please check this box.

☐ No ACP e-mail promotions. (By checking this, you limit promotional e-mails for ACP products and services; however, you will continue to receive general communications from the ACP such as the *Journal of Prosthodontic, Messenger,* etc.)

☐ No ACP mail communications or promotions. (By checking this box, you will **not** receive substantive membership benefits like the *Journal of Prosthodontics, Messenger,* or the Annual Session registration brochure.)

Applicant's Verification:
I hereby certify that the information on this application is correct. Your signature will also confirm your communication preferences listed above.

Applicant's Signature:____ Date:_________________________

Qualifications for Membership:
Global Alliance Membership in this College shall be limited to those individuals who have completed an advanced dental education program in prosthodontics that is not accredited by the Commission on Dental Accreditation of the American Dental Association.

For consideration the following *must* accompany your application:
1. Application and/or Reinstatement fee: $125 non-refundable
2. Annual Global Alliance Membership Dues are $472 per calendar year.
3. Copy of your certificate indicating that you have successfully completed an advanced dental education program in prosthodontics. The program must NOT have been accredited by the ADA's Commission on Dental Accreditation at the time you completed your program.

Method of Payment:

American Express ________ VISA ________ MasterCard ________ Check Enclosed ________

____
Card Holder's Name (Please print)

____
Card Holder's Signature

____
Credit Card Number Expiration Date

Mail or fax your completed application, payment and certificate to:

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Fax: (312) 573-1257
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